MDR Tracking Number: M5-04-1167-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-23-03.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 12/23/03, therefore the following dates of service are not timely: 12/3/02 through 12/13/02.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits/evaluations, therapeutic exercises, and myofascial exercises were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 1/2/03 through 2/10/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 15th day of March 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

March 11, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1167-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. On 10/17/02 the patient underwent x-rays of the cervical spine, shoulder, and forearm. On 12/5/02 the patient underwent an MRI of the cervical spine that showed slight generalized disc bulge at C5-6 with no spinal stenosis, cord compression, or foraminal narrowing identified, and mild straightening of the normal cervical lordosis. An EMG/NCV performed on 1/28/03 showed no evidence of cervical radiculopathy and possible demyelinating neuropathy. The diagnoses for this patient have included acute cervical strain, bilateral shoulder strain, contusion right forearm/strain, cervicalgia, myalgia and myositis. Treatment for this patient's condition has included physical therapy, work conditioning, a work hardening program and oral medications. The patient has also undergone paravertebral nerve blocks and trigger point injections.

Requested Services

Therapeutic exercises, office visit/evaluation, myofascial exercises from 1/2/03 through 2/10/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her cervical spine, shoulder and forearm on ___. The ___ chiropractor reviewer indicated that the patient sustained a sprain/strain injury. The ___ chiropractor reviewer explained that recovery time for this diagnoses is usually 6 to 8 weeks of treatment. The ___ chiropractor reviewer also explained that passive therapies should be phased out after use in the early treatment periods and that the physical therapy is appropriated in the later stages of care. However, the ___ chiropractor reviewer noted that the dates of service fall outside what is considered reasonable and necessary for a patient that has entered the chronic phase of injury. The ___ chiropractor reviewer explained that the TWCC treatment guidelines recommend trial reductions in care as the treatment progresses to allow for the natural healing. The ___ chiropractor reviewer indicated that the patient showed little improvement with therapy and no reductions were documented. The ___ chiropractor reviewer explained that the patient did not progress under this care. Therefore, the ___ chiropractor consultant concluded that the therapeutic exercises, office visit/evaluation, myofascial exercises from 1/2/03 through 2/10/03 were not medically necessary to treat this patient's condition.

Sincerely,